



Soccer Club Injury Report Form: This form is NOT to be completed by a parent.

INJURED PERSON: Player Official Coach Spectator Other _____

DATE: _____ TIME: am pm TEAM 1: _____ TEAM 2: _____

NAME: _____ Male Female BIRTHDATE: _____

ADDRESS: _____ CITY: _____ PC: _____

EMAIL: _____ PHONE: _____

NAME OF PARENT/GUARDIAN (If injured person is a minor): _____

NAME OF VENUE: _____
ADDRESS: _____
CITY: _____

FIELD SURFACE: (Circle)

- Grass
- Turf
- Dirt
- Indoor
- Pavement
- Cement
- Rubberized surface
- Other _____

TYPE OF PLAY:

- Training/Practice
- Scrimmage
- Game
- Other _____

REASON FOR INJURY:

- New Injury
- Aggravated Injury
- Recurrent Injury
- Illness
- Other _____

Was protective equipment worn on the injured body part?

- Yes No
- Type?(tape, brace, Shin guard, mouth guard, etc.)

BODY PART INJURED: Left/Right/NA

- Head Neck Finger Foot
- Eye Back Thumb Toe
- Ear Chest Thigh Internal
- Cheek Shoulder Knee None
- Nose Elbow Leg
- Chin Arm Shin
- Mouth Wrist Ankle
- Tooth Hand Other _____

NATURE OF INJURY/ILLNESS:

- Abrasion/Scratch Contusion Burn
- Laceration Respiratory Pain
- Puncture Contusion Nausea
- Avulsion Seizures Illness
- Fracture Cold Related Cardiac
- Dislocation Heat Related
- Subluxation Allergy Related
- Sprain Concussion
- Strain Other _____
- Loss of Consciousness

DESCRIPTION OF INJURY:

TIME:

- Before event
- During event
- After event

HOW DID IT HAPPEN:

- Collision with a player/referee
- Collision with an object
- Collision with a spectator
- Struck by a player
- Struck by an object
- Struck by ball
- Heading the ball
- Fall/stumble on same level
- Fall/stumble from a height
- Overstretch
- Overexertion
- Insect bee/sting
- Overuse
- Slip/Trip
- Temperature related (heat stress)
- Other _____

EXIT FROM INJURY SITE:

- Assisted by coach
- Assisted by players
- Assisted by _____
- Carried by coach
- Carried by players
- Carried by _____
- Ambulance
- Personal Vehicle

LOCATION:

- Playing field Sideline Concession area Restrooms
- Bleachers/Stands Parking lot Storage area
- Other _____

IF TREATED AT HOSPITAL:

- Transported by ambulance
- Transported by personal vehicle

IMMEDIATE TREATMENT:

- No treatment required
- Player refused treatment
- Parent refused treatment
- CPR
- AED
- Spine stabilization
- Ice, Compression, Elevation
- Rest
- Wound care
- Dressing for cuts/abrasions, etc.
- Sling
- Splint
- Brace
- Crutches
- Taping
- Stretching
- Fluids
- Food

CARE PROVIDED BY (name):

- Coach _____
- Parent _____
- Nurse _____
- Athletic Trainer, Certified _____
- Physician _____
- EMS _____
- Other _____

RETURN TO PLAY SAME DAY:

- Able to return, no restrictions
- Able to return, restrictions
- Able to return, but did not
- Unable to return to play

ADVICE GIVEN:

- Parents were notified
- No referral
- Referred to medical personnel
- Ambulance transport
- Hospital
- Need for x-rays
- Concussion Information
- Further assessment before allowed to return to activity
- Other _____

Person Completing Form:

Address:

Email:

Signature:

Position Title:

Phone:

Date:

Note: Persons without medical training should refer all medical decisions to appropriately qualified professionals. DO NOT attempt to diagnose injuries/illnesses. If the injured person's injury/illness does NOT improve in the following 24 hours, they MUST seek advice from their medical professional.

*Any head injury requires a doctor's approval for return to play.